MMG
MiltonMedicalGroup

Savitha Shama M.D.
Internal Medicine
P: 678.827.9157 **F: 470.299.6262**

Authorization to Release Medical Records

Name of Patient _____ Date(s) of Service _____

Date of Birth _____ Social Security Number _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above named patient.

PATIENT INFORMATION IS NEEDED FOR: Continuing Medical Care

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical	Consultation Report	Emergency Room Record
Operative Reports	Discharge Summary	Face Sheet
Lab/Path Reports	X-Ray Reports/Images	

The above information may be released to:

Milton Medical Group
Dr. Savitha Shama
735 N Main ST STE 1100
Alpharetta, GA 30009
PH: 678-827-9157
Fax: 678-401-0292

FROM: ***(Please enter information of provider from where we need to obtain your medical records)***
Provider Name:

Street Address:

City: State: ZIP:

Phone: _____ Fax: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Signature: _____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative

_____
Relationship to Patient